

APPARATUS AND METHOD FOR DETECTING ATRIAL FIBRILLATION

BACKGROUND OF THE INVENTION

1. Field of the Invention

The subject invention pertains to a method for detection of atrial
5 fibrillation, and an apparatus suited therefor.

2. Description of the Related Art

Acquired illnesses of the heart can be divided into illnesses of the
endocardium, of the myocardium, of the pericardium, and of the conduction system.

10 Systematic recording and consideration of the classical risk factors
such as excess weight, high blood pressure or a high cholesterol level allows no
more than barely 60% of the patients at risk to be identified in good time.

Invasive clinical examination methods, such as the cardiac catheter
method, which is carried out 500,000 times a year in Germany alone and is
15 associated with considerable risks, allow a reliable prediction of whether the patient
examined is under threat of a heart attack at present or any other illness of the heart.
One patient in a thousand dies with this method of diagnosis, however.

Non-invasive clinical methods of examination, such as
electrocardiography, are not associated with such great safety risks. However, the
20 clinical standing and reliability of this diagnostic are likewise unsatisfactory on the
basis of the prior art and is too greatly dependent on the frequency with which the
individual symptoms occur over time.

Electronic imaging methods, such as magnetic resonance imaging,
will replace the invasive cardiac catheter method over the course of time. Electronic

imaging methods allow inflammatory foci in vessels to be easily identified, and in principle to also be easily diagnosed as a result of their different tissues. However, this equipment represents a high capital investment and is also very cost-intensive in diagnostic use. Moreover, it is ill-suited to long-term observation, since patients
 5 generally cannot tolerate the relatively long time spent in the narrow tubes for accommodating the body.

Biochemical methods are generally based on blood examinations using “biomarkers”. The best known method involves measuring the protein CRP, which indicates inflammatory processes in the body. This “CRP test” gives an
 10 indication allowing a patient’s health risk to be estimated at least more precisely.

One good way of detecting various cardiac damage early on an electronic basis is provided by the actual heart’s electrophysiological conduction system. The conduction system manifests itself differently in the individual tissue types through different electrical potential patterns, produced electrophysically by
 15 electrical polarization and depolarization.

Besides the ventricular and supraventricular extrasystoles, atrial fibrillation is the most frequently occurring arrhythmia. Assuming a mean prevalence of atrial fibrillation between 0.4% and 1% of the population, there are between 330,000 and 830,000 citizens affected in Germany alone. Taking into
 20 account the fact that atrial fibrillation also increases with age and that the proportion of older people in the total population is increasing, the number of people affected will naturally also rise continually.

Atrial fibrillation is characterized by electrical excitation waves which propagate without synchronization in the atrial myocardium and result in chaotic
 25 depolarization sequences with hemodynamically ineffective atrial constrictions.

These biophysical conformities to basic laws were the starting point for development of the clinical non-invasive electrophysical diagnosis method of electrocardiography, i.e. of curve-based recording of the electrical excitation waves

in the “electrocardiograms” (ECG). From the ECG it is possible to infer the heart rhythm, the heart rate, the ectopic beat and the conduction, in principle using different methods and with varying exactness. A distinction is drawn between ECG at rest, ECG under stress and long-term ECG.

5 In the case of atrial fibrillation, the ECG at rest shows “QRS complexes” arranged at irregular times (this is referred to as absolute arrhythmia), while the baseline has irregular fibrillation waves (the “f waves”) of different amplitude and shape. Depending on the arrangement of the electrodes on the patient’s body, the fibrillation waves cannot be identified with sufficient safety in
10 all measurements, which means that the diagnosis “atrial fibrillation” can be ascertained to a sufficient extent only from the temporally irregular successions of the QRS complexes. With very fast and very slow ventricular transmission, however, the ventricular rate can appear relatively regular, giving rise to the possibility of an incorrect diagnosis of “absolute arrhythmia”.

15 It is therefore necessary for the RR intervals for the QRS complexes to be evaluated very precisely over a relatively long period of time in order to keep the measurement deviations for rate determination in the ECG at rest within permissible limits.

20 The ECG under stress is a test method for estimating the heart rate under rest and stress conditions. It can thus be used to estimate the biological effectiveness of antiarrhythmics. A reduction in the heart rate does not always signify an improvement in the heart’s work, however. The ECG under stress thus cannot sufficiently detect the functional cardiopulmonary stages of a patient with atrial fibrillation.

25 The long-term ECG is a measurement method for detecting and recording proximally occurring atrial fibrillation. There is thus the opportunity to detect both spontaneously occurring intermittent disturbances in rhythm and “trigger arrhythmia”. Normal measurement times are approximately 24 to 72 hours. Long-term electrocardiography is probably the most important method of detecting

and hence of diagnosing atrial fibrillation at present. Its value is in the diagnosis of symptoms which occur at least once a week. Events which occur less frequently cannot be detected using this measurement method, however. Since the unit is relatively heavy, its use on a mobile basis is limited, which means that the measurement time cannot be increased to the extent required medically.

This problem can be significantly alleviated using the "event recorder". This is an ECG recorder which, like the long-term ECG, is fixed to the patient using electrodes but has a much lower weight and physical volume. However, the recorder, weighing only a few grams, has a markedly limited storage capacity which permits ECG recording over just three minutes. The result of this is that the patient needs to press an event button when a clinical event occurs in order to start the ECG storage. Clinical experiences using the event recorder to detect atrial fibrillation are therefore also very limited. Following a recent study, a correct ECG diagnosis was able to be made in only 68% of a statistical collective with symptoms such as "palpitations", for example.

In summary, it can be said that the measurement and hence also the diagnostic certainty is too greatly dependent upon the frequency of occurrence of the corresponding symptoms. Hence, the clinical standing of this non-invasive diagnostic is not very high.

WO 02/24086 A1 discloses a system for detecting atrial fibrillation, including an evaluation circuit which calculates the distribution of RR intervals from the patient's heart potentials and compares it with at least one known distribution to generate a state signal representing the state of the patient's heart. This system involves measuring the RR intervals, forming a histogram of the ΔRR deviations, and comparing the histogram with histograms of other patients suffering from arrhythmia.

SUMMARY OF THE INVENTION

The present invention is based on the object of providing an apparatus and a method for reliable non-invasive detection of atrial fibrillation. This and other objects are achieved by repetitively obtaining a plurality of groups of n successive RR intervals from a patient's heart potentials, n being a natural number greater than 1, defining a plurality of points in an n -dimensional space of numbers, each point representing one of said groups of n successive RR intervals, to form a characteristic distribution of said points, comparing said characteristic distribution with at least one normal distribution derived from a healthy heart, and generating a state signal representing the state of the heart from said deviation.

An apparatus capable of performing these functions can be produced as a lightweight, battery-operated, non-invasive, bioelectronic measuring apparatus for electrophysically sensing bioelectrical heart potentials with numerical algorithm-assisted electronic evaluation and electronic display for safe diagnosis of atrial fibrillation at a very early time in the illness.

BRIEF DESCRIPTION OF THE DRAWINGS

FIGURE 1 shows a diagram showing the timing of the heart potentials derived using electrodes (ECG),

FIGURE 2 shows a graphical illustration to explain a three-dimensional point structure formed from the ECG shown in Fig. 1,

FIGURE 3 shows the point structure obtained from the long-term ECG for a healthy heart using the method explained in Fig. 2,

FIGURE 4 shows a point structure obtained in the same way from the long-term ECG for a heart suffering from atrial fibrillation, and

FIGURE 5 shows a block diagram of an apparatus for detecting atrial fibrillation.

DETAILED DESCRIPTION OF THE PREFERRED EMBODIMENT

In the graphical illustration of the long-term ECG, a detail from which is shown in Fig. 1, in the form of a "scatter plot", three successive RR intervals are always measured in the temporal order of the QRS complexes and are graphically represented in a three-dimensional space of numbers as a point triplet in Fig. 2, where the length of the RR intervals denoted by X, Y and Z in Fig. 1 is plotted on the three axes of the diagram and hence gives the three-dimensional position of a point P (x,y,z).

For a healthy subject, this method of evaluation provides a three-dimensional club-shaped point structure, as illustrated in Fig. 3. By contrast, in the presence of atrial fibrillation, there is always an easily identifiable geometrical point structure, significantly different than the club geometry, in the form of a trapezium in three-dimensional orientation.

If only two successive RR intervals are respectively plotted on a two-dimensional diagram, then the general triangular point structure shown in Fig. 4 is formed.

This biophysical conformity to law forms the basis for the technical structure of the measuring apparatus. From the ECG, a list of the measured RR intervals is stored and these are used to produce a virtual electronic, preferably two-dimensional, scatter plot. Using a pre-programmed algorithm, the virtual scatter plot is electronically checked for the presence of a corresponding point structure (in the two-dimensional representation of the triangle structure) and if the pattern correlates with one associated with atrial fibrillation, a visual or audible indicator is given to identify the risk of possible atrial fibrillation which is imminent or is already occurring.

The measuring apparatus can be designed to be a lightweight easily portable electronic unit which does not bother the patient much during the measuring time. The measurements can be taken by the patient independently and regardless of the respective location. The display of the result of analysis is simple, which means that the patient can immediately identify his health status and can immediately go to the nearest hospital or to a corresponding specialist physician in the event of any risk.

Fig. 5 shows the electrical block diagram for the battery-operated voltage-stabilized technical implementation of the measuring apparatus. This comprises three measuring electrodes 10 for signal derivation, a battery-powered constant (not shown) for supply voltage to the electronic assemblies, an analog block 20 for analog signal conditioning, a digital block 30 for signal processing and a display unit 40 with optoelectronic and piezoelectrical actuators. The analog block 20 comprises a highly linear, programmable-gain, broadband preamplifier 21 with very low temperature drift, a multiple electronic filter 22 and a highly linear main amplifier 23, which likewise has a very low temperature drift. The digital block 30 comprises an A/D converter 31, a sample-and-hold stage 32, a microcontroller 33 and a RAM store 34. The A/D converter 31 and the sample-and-hold stage 32 are clock-controlled by the microcontroller 33. Alternatively, the A/D converter can be integrated in the microcontroller 33. A signal from the microcontroller 33 is fed back to the control input on the preamplifier 21 in order to regulate the gain.

The three measuring electrodes 10 are used to derive the (very weak) bioelectrical potential signals from the patient's heart, and these signals are supplied directly to the preamplifier 21 via signal lines, which are shielded if appropriate. The preamplifier 21 generates from the potential signal a preamplified electrical voltage signal. The filter 22 situated between the preamplifier 21 and the main amplifier 23 is used to separate noise signal components from the useful signal components, to perform pulse shaping and to prevent antialiasing effects. The signal conditioned in this manner is re-amplified using the main amplifier 23, so that the A/D converter 31 can be actuated in line with its electrical specification.

In clocked interaction with the sample-and-hold stage 32, the A/D converter 31 generates from the analog voltage signal a corresponding digital bit sequence which is read into the memory 34 in temporal order using the microcontroller 33. The digital data material is digitally compressed and is processed, is coded, and is compared with a reference structure which is likewise stored in the memory 34.

The measuring time can be varied between the 30 and 60 minutes. When the chosen measuring time has elapsed, the result of analysis is displayed, preferably visually, using the electronic display unit 40. Since the risk of atrial fibrillation can be formally divided into four stages, the display unit 40 is designed such that it distinguishes between four different states. This can be done using a graphical LCD having four bars or a pie chart divided into quadrants. In the example illustrated in Fig. 5, four differently colored light-emitting diodes (LEDs) 41 are provided.

If the red LED 41 lights, then the occurrence of the event (atrial fibrillation) is highly likely. If the yellow LED 41 lights, the occurrence of the event is likely. If the blue LED 41 lights, then the occurrence of the event is not very likely. If the green LED 41 lights, then there is currently no risk at all of the occurrence of the event.

To ensure correct operation of the unit during the measuring time, the display unit 40 can have an integrated piezoacoustic signal generator 42 for monitoring the state of the battery, said piezoacoustic signal generator generating a beep if the battery voltage is too low and thereby requesting replacement of the battery before the measurement. Alternatively, the visual display can be furnished with a flash function.

Another opportunity for using the apparatus described here is for a routine cardiac examination as part of a general health examination in order to store the typical club-shaped point structure produced for the healthy patient and

subsequently to program it into a unit as a reference structure in order to allow successful early detection.

5 In addition, the apparatus can be used for early detection of strokes. According to examinations by the German foundation for stroke support and on the basis of the current medical level, there is a direct link between arrhythmia/atrial fibrillation and the occurrence of a stroke. According to the Erlangen register of the German stroke support, 27% of all cerebral infarctions are based on arrhythmia.

10 In this context, atrial fibrillation, a form of arrhythmia, is particularly in danger of giving rise to a stroke. In this case, the heart now pumps only in an irregular manner. Owing to the fact that the atrium makes only fluttering movements and no longer contracts regularly, there is an increased risk of blood clots (emboli) forming in the atrium. If these migrate to the brain, they close off vessels and trigger a stroke.

15 The safe diagnosis of atrial fibrillation as early as possible in the illness has a significant influence on early detection of people who are at risk of strokes.